Commonwealth
INDEMNITY PLAN PLUS
The PLUS Plan
Benefit Updates and Important Information

SERIES 4
EFFECTIVE
JULY 1, 2005

Commonwealth of Massachusetts
Group Insurance Commission

UniCare®

Updates to the Commonwealth Indemnity Plan PLUS Member Handbook

This booklet contains important updates to your Commonwealth Indemnity Plan PLUS (the PLUS Plan) coverage, effective July 1, 2005. Please keep this booklet, together with your Series 4 Member Handbook and 2004 benefit update, in a convenient place for easy access when you need to refer to your health plan information.

If you have any questions about the changes to your **medical plan** benefits, please call the Commonwealth Service Center at **1-800-442-9300**, Monday through Thursday from 8:30 a.m. to 6:00 p.m., and Friday from 8:30 a.m. to 5:00 p.m. If you are deaf or hard of hearing and have a TDD machine, contact us on our TDD lines at 1-800-322-9161 or 1-978-474-5163. A customer service representative will be happy to help you.

For questions about your **prescription drug plan** benefits, please call Express Scripts at **1-877-828-9744**.

There are no changes to your **mental health/substance abuse** benefits, which are provided by United Behavioral Health (UBH). If you have any questions about these benefits, call UBH at **1-888-610-9039**.

This benefit update has also been added to the Plan's web site at **www.unicare-cip.com**.

Note: The page references in this document refer to Member Handbook pages, unless otherwise specified.

Your Identification Card – You will receive your medical plan identification (ID) card in a separate mailing. If you are a current Plan member, please note that your new ID card will show your new office visit copay of $15.

Benefit Changes

Preventive Care

Item 24 (d) (Preventive Care Schedule) on page 41 of the Description of Covered Services section is changed to add coverage for bone mineral density testing and to modify the description of coverage for cholesterol screening, as follows:

- Bone mineral density testing for screening purposes every two years for women over age 40
- Blood cholesterol level (every five years), including high density cholesterol (HDL) and low density cholesterol (LDL), in addition to total cholesterol

Item 4 (bone density testing) on page 48 of the Limitations section of the Series 4 Member Handbook is deleted and replaced with the following:

4. Bone density testing is not covered when done solely for the purpose of screening or prevention, except as described in Item 24 (d) (Preventive Care Schedule) above.

Office Visit Copay

The office visit copay has changed from $10 to $15 per visit for the following services:

Physician Services *(see page 30 of the Benefit Highlights section)*

	PLUS Provider	Non-PLUS Provider
Physician Services		📖 Also see page 40
Non-Emergency Treatment at Home, Office or Outpatient Hospital	100% after a $15 copay per visit. The copay applies only to the first 15 visits[1] in a calendar year. The copay does not count toward the out-of-pocket maximum.	80% after a $15 copay per visit and after the calendar year deductible. The copay applies only to the first 15 visits[1] in a calendar year. The copay does not count toward the out-of-pocket maximum.
Chiropractic Care or Treatment	80% after a $15 copay per visit; maximum benefit of $40 per visit, 20 visits per calendar year. The copay applies only to the first 15 visits[1] in a calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.	80% after a $15 copay per visit; maximum benefit of $40 per visit, 20 visits per calendar year. The copay applies only to the first 15 visits[1] in a calendar year. The 20% coinsurance amount does not count toward the out-of-pocket maximum.

Preventive Care *(see page 31 of the Benefit Highlights section)*

	PLUS Provider	Non-PLUS Provider
Preventive Care		📖 Also see pages 40-41
Office Visits (refer to frequency limits on pages 40-41)	100% after a $15 copay per visit. The copay does not count toward the out-of-pocket maximum.	80% after a $15 copay per visit. The copay does not count toward the calendar year deductible or the out-of-pocket maximum.
Annual Gynecological Visits	100% after a $15 copay per visit	80% after a $15 copay per visit

Family Planning Services *(see page 34 of the Benefit Highlights section)*

	PLUS Provider	Non-PLUS Provider
Family Planning Services		📖 Also see page 38
Office Visits and Procedures	100% after a $15 copay per visit	100% after a $15 copay per visit

In the examples provided under “Individual Calendar Year Deductible” and under “Copayments” on pages 6 and 8, respectively, of the Series 4 Member Handbook, the words "$10 copay” are deleted and replaced with “office visit copay.”

Inpatient Hospital Quarterly Deductible

The PLUS Plan now has tiered deductibles for inpatient care at Massachusetts acute care hospitals. You pay a $200 quarterly inpatient deductible when you use a Tier 1 PLUS hospital, and $400 for Tier 2 PLUS hospitals and non-PLUS hospitals. (There is a maximum of one inpatient hospital deductible per calendar year quarter.)

Hospitals are designated as Tier 1 or Tier 2 based upon an evaluation of cost, how efficiently they use their resources and whether they meet certain quality measures.

For additional information on hospital tiering, log onto **www.unicare-cip.com**.

You pay a $200 deductible when you receive inpatient care at the following hospitals:

- Those designated as Tier 1 (see Appendix D on page 11 of this booklet)
- Any hospital when you are admitted from its emergency room, even if it is not a Tier 1 PLUS hospital
- Additional hospitals designated by the Plan for certain complex procedures and high-risk maternity care (see Appendix E on page 12 of this booklet)
- All PLUS rehabilitation hospitals
- All PLUS hospitals located outside Massachusetts

You pay a $400 deductible when you receive inpatient care at:

- Any Massachusetts PLUS acute care hospital designated as Tier 2 (see Appendix D on page 11 of this booklet)
- Any non-PLUS hospital

This change to inpatient hospital deductibles is reflected in the Series 4 Member Handbook as follows:

A) The first bulleted item under "How to Receive the Highest Level of Benefits from Your Medical Plan" on page 3 of the Series 4 Member Handbook is deleted and replaced with the following:

- Use PLUS providers for hospital and physician services. For a comparison of benefits when you use PLUS providers versus non-PLUS providers, please refer to the Benefit Highlights section. To save on out-of-pocket costs for inpatient hospital care, use a Tier 1 PLUS hospital. For a list of Tier 1 and Tier 2 hospitals:
  - See Appendix D on page 11 of this booklet
  - Check the online PLUS Provider Directory (log onto www.unicare-cip.com and click on "Provider Search")
  - Check the printed version of the PLUS Provider Directory

B) The chart on page 6 of the Your Costs section of the Series 4 Member Handbook is deleted and replaced with the following:

Deductibles

A deductible is a fixed dollar amount you pay for certain services before the Plan begins paying benefits for you or a covered dependent. The deductible amounts you must satisfy are shown in the chart below.

Deductibles	When You Use a PLUS Provider	When You Use a Non-PLUS Provider
Individual Calendar Year Deductible	None	$100
Family Calendar Year Deductible	None	$200 (two family members must each incur $100 of covered expenses to satisfy the family calendar year deducible)
Inpatient Hospital Quarterly Deductible	$200/$400 *	$400
Outpatient Surgery Quarterly Deductible	$75	$75

* To find out which hospitals have a $200 inpatient deductible and which have a $400 inpatient deductible, see "Inpatient Hospital Quarterly Deductible" on page 4 of this booklet.

C) The subsection "Inpatient Hospital Quarterly Deductible" on page 7 of the Your Costs section of the Series 4 Member Handbook is deleted and replaced with the following:

Inpatient Hospital Quarterly Deductible

The inpatient hospital quarterly deductible is a per-person, per-calendar year quarter deductible. Each time you or a covered dependent is admitted to a hospital, you are responsible for this deductible. However, once a covered person satisfies this deductible in any calendar year quarter, he or she will not have to satisfy the deductible again during that same calendar year quarter. This deductible does not apply toward the individual calendar year deductible.

For example: If you are admitted to a PLUS hospital in January and stay overnight, you will be responsible for paying the applicable inpatient deductible. If you were re-admitted to a PLUS hospital in March, you will not have to pay another deductible, as March is in the same calendar quarter as January. However, if you were re-admitted to a PLUS hospital in May, you will incur another $200 inpatient deductible.

Outpatient Physical Therapy and Occupational Therapy

The coverage for outpatient physical therapy and occupational therapy, which is included under the heading "Outpatient Medical Care" on page 29 of the Benefit Highlights section of the Series 4 Member Handbook, is deleted and replaced with the following:

	PLUS Provider	Non-PLUS Provider
Outpatient Medical Care		🕮 Also see pages 36-42
☎ Physical Therapy and ☎ Occupational Therapy	100% after $15 copay	100% after $15 copay and after the calendar year deductible

Benefit Clarifications

Exclusions

The following items have been added to the Exclusions section on pages 45-47 of the Series 4 Member Handbook:

- Anesthesia and other services required for the performance of a service that is not covered under the Plan. Non-covered services include those for which there is no Plan benefit and those which the Plan has determined to be not medically necessary.
- Orthodontic treatment, including treatment done in preparation for surgery
- Virtual colonoscopy/virtual colonography (standard colonoscopy, however, is covered)
- Any type of thermal therapy device
- A service or supply required by a third party that is not otherwise Medically Necessary. Examples of a third party are an employer, an insurance company, a school or a court.

Item 30 in the list of Exclusions on page 46 of the Series 4 Member Handbook is deleted and replaced with the following:

30. Certain manipulative or physical therapy services, including but not limited to: paraffin treatment; microwave, infrared and ultraviolet therapies; diathermy; massage therapy; acupuncture; aerobic exercise; rolfing therapy; Shiatsu; sports conditioning/weight training; craniosacral therapy; kinetic therapy; or therapies performed in a group setting

Plan Definitions

The definition for Manipulative Therapy in the Plan Definitions section on page 53 of the Series 4 Member Handbook is deleted and replaced with the following:

"Manipulative Therapy" – hands-on treatment provided by a chiropractor, osteopath or physician by means of direct manipulation, exercise, movement or other physical modalities applied to the body to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system or following the loss of a body part. For examples of manipulative therapies that are not covered, see Exclusion 30 above.

The definition for Physical Therapy in the Plan Definitions section on page 54 of the Series 4 Member Handbook is deleted and replaced with the following:

"Physical Therapy" – hands-on treatment provided by a licensed physical therapist by means of direct manipulation, exercise, movement or other physical modalities to relieve pain, restore function and/or minimize disability as a result of disease or injury to the neuromuscular and/or musculoskeletal system or following the loss of a body part. For examples of non-covered physical therapy services, see Exclusion 30 above.

The following definition is added to the Plan Definitions section on pages 50 to 56 of the Series 4 Member Handbook:

"Tiers" – Different levels into which the Plan groups providers based upon an evaluation of cost, how efficiently they use their resources and whether they meet certain quality measures.

Managed Care Notification Requirements

The following chart replaces the Managed Care Notification Requirements chart on pages 18-19 of the Series 4 Member Handbook.

Please note that when you use a PLUS provider, the PLUS provider is responsible for the Plan's notification requirements.

Managed Care Notification Requirements	
Treatment / Service	**Notification Requirement**
Selected Procedure Review: Some of these procedures may be performed in a doctor's office.	At least seven (7) calendar days before the procedure for **non-emergency** procedures. If you are not sure whether or not your procedure is subject to these notification requirements, please call the Commonwealth Service Center at 1-800-442-9300.
Procedure	**Definition**
Arthroscopy of the knee for diagnostic purposes only ***NEW** *	Examination of the interior of the knee using an endoscope that is inserted into the joint through a small incision
Cholecystectomy	Removal of the gallbladder by any method
CT Scans – Computerized Axial Tomography: • Abdomen and/or Pelvis	Special computerized x-ray of the abdomen or pelvis
• Cervical Spine	Special computerized x-ray of the neck
• Thoracic Spine	Special computerized x-ray of the middle back
• Lumbosacral Spine	Special computerized x-ray of the lower back
• Thoracic Cavity	Special computerized x-ray of the chest
Dilation and Curettage (D & C)	Stretching the cervix and removing or destroying the endometrial lining
Diskectomy of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lower back

*** Effective July 1, 2005, this procedure has been added to the list of procedures for which the Plan requires notification.**

Managed Care Notification Requirements

(continued)

Procedure	Definition
Hysterectomy	Removal of the uterus (through the abdomen or vagina) by any method
Hysteroscopy and / or Hysteroscopic Endometrial Ablation	Examination through a telescopic tube (hysteroscope) of the inside of the uterus for diagnosis and / or treatment such as removal or destruction of the endometrial lining or lesions such as fibroids or polyps
Laminectomy/Laminotomy of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
MRI – Magnetic Resonance Imaging:	
• Abdomen and/or Pelvis	Imaging study of the abdomen or pelvis
• Cervical Spine	Imaging study of the neck
• Knee ***NEW ****	Imaging study of the knee
• Thoracic Spine	Imaging study of the middle back
• Lumbosacral Spine	Imaging study of the lower back
• Thoracic Cavity	Imaging study of the chest
Pelvic Laparoscopy	Examination through a telescopic tube (laparoscope) of the inside of the pelvis (the lower abdominal area) for diagnosis and/or treatment, aspiration, removal or destruction of abnormalities of the ovaries, fallopian tubes, uterus, female pelvic organs or surrounding structures
Sinus Surgery	Any procedure by any method that opens, removes or treats the nasal sinuses
Spinal Fusion of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
Spinal Instrumentation of the Lumbosacral Spine	Any surgical procedure by any method to relieve pressure on the spinal cord or nerve roots in the lumbosacral spine (lower back)
UGI Endoscopy	Examination through a flexible telescopic tube (endoscope) of the upper gastrointestinal (UGI) area (that is, the esophagus, stomach and duodenum) for diagnosis and/or treatment

*** Effective July 1, 2005, this procedure has been added to the list of procedures for which the Plan requires notification.**

The Plan no longer requires notification for colonoscopy as of July 1, 2005. Please note that the Plan does not cover virtual colonoscopy/virtual colonography, a three-dimensional CT scan of the abdomen.

Important Plan Information

Do You Have Medical Coverage under Another Health Plan?

If you have medical benefits under another health plan in addition to the Commonwealth Indemnity Plan, you need to let us know by completing our "Other Health Insurance" form. This way, we can work with the other health plan to determine which plan has primary responsibility for providing coverage for each service.

This is called "coordination of benefits." This provision lets members with dual coverage use the coverage available to them under both health plans.

You must also complete the Other Health Insurance form if any of your **family members** covered under the Commonwealth Indemnity Plan have medical benefits under another health plan.

Important: **You don't have to complete the Other Health Insurance form if you only have health plan coverage under the Commonwealth Indemnity Plan. It is not necessary to tell us about coverage under MassHealth or TriCare, or about other types of coverage such as dental, vision or life insurance plans.**

How to Get a Copy of the "Other Health Insurance" Form

- ***New*** **Plan Members**: You'll find this form in your welcome package.
- ***Renewing*** **Plan Members**: You can download this form from our web site at www.unicare-cip.com by clicking on the link for "Other Health Insurance Form" on the Forms and Documents web page. Or call us at 1-800-442-9300 to request the form.

Need Help?

If you're not sure whether you need to complete the Other Health Insurance form, a customer service representative can help you. Please call 1-800-442-9300.

Resources Available on the Plan's Web Site

The Plan's web site, **www.unicare-cip.com**, offers you an extensive range of Plan-related and general health care information and resources. These resources give you the ability to:

- Check the status of your claims.
- Find out about the Plan's discounts on a variety of health-related products and services.
- Access information to help you understand and manage various health conditions and treatment procedures with the Healthcare Advisor™. This resource also provides profiles of health care facilities to help you assess where to best receive care, based on your needs and preferences.
- Learn what's being done to improve patient safety in hospitals and how this information may help you select a hospital. Find out the extent to which hospitals in your area have implemented safety initiatives developed by the Leapfrog Group for Patient Safety, and how frequently they have performed certain procedures.
- Research medical information with the Healthwise® Knowledgebase, an extensive online database of unbiased, up-to-date medical information.
- Access important Plan information, such as notification requirements.
- View your Member Handbook, benefit updates and detailed descriptions of certain Plan benefits.
- Check our listing of Preferred Vendors for services such as home health care, and for products such as durable medical equipment and medical supplies.
- Order Plan materials, e-mail the Plan and more.

Appendix D: List of PLUS Tier 1 and Tier 2 Hospitals

The following list of PLUS Tier 1 and Tier 2 acute care hospitals is added to the Appendices section of the Series 4 Member handbook as Appendix D.

PLUS Plan Tier 1 Hospitals

- Addison Gilbert Hospital, Gloucester
- Anna Jaques Hospital, Newburyport
- Athol Memorial Hospital, Athol
- Baystate Medical Center, Springfield
- Beth Israel Deaconess Medical Center, Boston
- Beth Israel Deaconess Medical Center, Needham
- Beverly Hospital, Beverly
- Cape Cod Hospital, Hyannis
- Caritas Norwood Hospital, Norwood
- Charlton Memorial Hospital, Fall River
- Children's Hospital, Boston
- Clinton Hospital, Clinton
- Cooley Dickinson Hospital, Northampton
- Fairview Hospital, Great Barrington
- Franklin Medical Center, Greenfield
- Harrington Memorial Hospital, Southbridge
- Heywood Hospital, Gardner
- Jordan Hospital, Plymouth
- Lawrence Memorial Hospital, Medford
- Marlborough Hospital, Marlborough
- Mary Lane Hospital, Ware
- Melrose-Wakefield Hospital, Melrose
- MetroWest Medical Center – Framingham Union Hospital, Framingham
- MetroWest Medical Center – Leonard Morse Hospital, Natick
- Milton Hospital, Milton
- Morton Hospital and Medical Center, Taunton
- Nashoba Valley Medical Center, Ayer
- New England Baptist Hospital, Boston
- Noble Hospital, Westfield
- North Adams Regional Hospital, North Adams
- North Shore Children's Hospital, Salem
- North Shore Medical Center – Salem Campus, Salem
- North Shore Medical Center – Union Campus, Lynn
- Quincy Medical Center, Quincy
- Saints Memorial Medical Center, Lowell
- St. Luke's Hospital, New Bedford
- Tobey Hospital, Wareham
- Winchester Hospital, Winchester
- Wing Memorial Hospital and Medical Centers, Palmer

PLUS Plan Tier 2 Hospitals

- Berkshire Medical Center, Pittsfield
- Boston Medical Center, Boston
- Brigham and Women's Hospital, Boston
- Cambridge Hospital, Cambridge
- Caritas Carney Hospital, Boston
- Caritas Good Samaritan Medical Center, Brockton
- Caritas Holy Family Hospital, Methuen
- Caritas St. Elizabeth's Medical Center, Boston
- Dana-Farber Cancer Institute, Boston
- Falmouth Hospital, Falmouth
- Faulkner Hospital, Boston
- HealthAlliance Hospital, Burbank
- HealthAlliance Hospital, Leominster
- Hillcrest Hospital, Pittsfield
- Lahey Clinic, Burlington
- Lawrence General Hospital, Lawrence
- Lowell General Hospital, Lowell
- Mass Eye and Ear Infirmary, Boston
- Massachusetts General Hospital, Boston
- Mount Auburn Hospital, Cambridge
- Newton-Wellesley Hospital, Newton
- Somerville Hospital, Somerville
- South Shore Hospital, South Weymouth
- St. Anne's Hospital, Fall River
- The Floating Hospital for Children at Tufts–New England Medical Center, Boston
- Tufts–New England Medical Center, Boston
- UMass Memorial Medical Center – Memorial Campus, Worcester
- UMass Memorial Medical Center – University Campus, Worcester
- Whidden Memorial Hospital, Everett

Appendix E: Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care

The following chart, "Designated Hospitals for Select Complex Inpatient Procedures and High-Risk Maternity Care," is added to the Appendices section of the Series 4 Member Handbook as Appendix E.

There is a $200 deductible per calendar quarter for inpatient care at all PLUS acute care hospitals located in Massachusetts that are designated as Tier 1 in Appendix D on page 11 of this booklet. The PLUS Plan also provides access to the following additional hospitals for certain complex procedures at the $200 deductible level, as indicated in the chart below.

	Boston Medical Center	Brigham and Women's Hospital	Caritas St. Elizabeth's Medical Center	Massachusetts General Hospital	Lahey Clinic	Tufts-New England Medical Center	Mount Auburn Hospital	UMass Memorial Medical Center
Cardiac Valve Procedures		X		X	X			X
Knee Replacement		X		X	X			X
Hip Replacement		X		X	X			X
Discectomy and Laminectomy	X	X		X	X			X
Spinal Fusion		X		X	X			X
High Risk Deliveries & Neonatal ICUs*	X	X	X		X		X	X
Pancreatic Resection*	X	X	X	X	X		X	X
Esophagectomy*	X	X		X	X		X	
Abdominal Aortic Aneurysm Repair*		X		X	X	X		X
Percutaneous Coronary Intervention*		X	X	X	X	X	X	X
Coronary Artery Bypass*	X	X	X	X	X		X	X

* These procedures have been designated by the Leapfrog Group for Patient Safety as complex procedures that studies indicate are most safely performed at hospitals that meet the following criteria: 1) they have significant experience in performing the procedure, and 2) they comply with specific clinical practices established by the Leapfrog Group.

Important Information from the Group Insurance Commission about Your HIPAA Portability Rights

This notice describes certain HIPAA protections available to you under federal law when changing your health insurance coverage. If you no longer have coverage under any health plan offered through the Group Insurance Commission (GIC), you may need to provide evidence of your prior coverage in order to:

- enroll in another group plan
- reduce a waiting period in another group health plan, or
- get certain types of individual coverage, even if you have health problems

Using Certificates of Creditable Coverage to Reduce Pre-existing Condition Exclusion Waiting Periods
Some group health plans restrict coverage of individuals with certain medical conditions before they apply. These restrictions, known as "pre-existing condition exclusions," apply to conditions for which medical advice, diagnosis, care or treatment was recommended or received within six months before the individual's enrollment date. (An enrollment date is the first day of coverage under the plan, or if there is a waiting period, the first day of a waiting period, usually the first day of work). Under HIPAA, pre-existing condition exclusion periods cannot last longer than 12 months after your enrollment date (18 months if you are a late enrollee). Pre-existing condition exclusion periods cannot apply to pregnancy, or to children who enrolled in health coverage within 30 days after their birth, adoption, or placement for adoption.

If your new plan imposes a pre-existing condition exclusion period, the waiting time before coverage begins must be reduced by the length of time during which you had prior "creditable" coverage. Most health coverage, including that provided by the GIC, Medicaid, Medicare and individual coverage, is creditable coverage. You may combine any creditable coverage you have, including your GIC coverage, to reduce the length of a pre-existing condition exclusion period required by a new plan. However, if at any time you had no coverage for 63 or more days, a new plan may not have to count the coverage period you had before the break. (However, if you are on leave under the Family and Medical Leave Act [FMLA] and you drop health coverage during your leave, any days without coverage while on FMLA leave do not count towards a 63-day break in coverage.)

When You Have the Right to Specially Enroll in Another Plan
If you lose your group health plan coverage, you may be able to get into another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees. In order to do so, however, you must request enrollment within 30 days of your group coverage termination. Marriage, birth, adoption or placement for adoption can also trigger these special enrollment rights. **Therefore, if you have such a life event or your coverage ends, you should request special enrollment in another plan as soon as possible if you are eligible for it.**

You Have the Right Not to Be Discriminated Against Based on Health Status
A group health plan may not refuse to enroll you or your dependents based on anything related to your health, nor can the plan charge you or your dependents more for coverage, based on health factors, than the amount it charges similarly situated individuals for the coverage.

When You Have the Right to Individual Coverage
If you are eligible for individual coverage, you have a right to buy certain individual health policies without being subject to a pre-existing condition exclusion period. To be an eligible individual, you must meet the following requirements:

- You have had coverage for at least 18 months without a break in coverage of 63 days or more.
- Your most recent coverage was under a group health plan.
- Your group coverage was not terminated because of fraud or nonpayment of premium.
- You are not eligible for another group health plan, Medicare or Medicaid, and do not have any other health insurance coverage.

Therefore, if you are interested in obtaining individual coverage and you meet the criteria to be eligible, you should apply for this coverage as soon as possible to avoid forfeiting your eligibility due to a 63-day break.

Questions?
If you have questions about your HIPAA rights, contact the Massachusetts Division of Insurance at 1-617-521-7777, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272.

Prescription Drug Benefit Plan

Administered By:

EXPRESS SCRIPTS®

www.express-scripts.com

Description of Benefits

Express Scripts is the pharmacy benefit manager for your prescription drug benefit plan.

If you have any questions about your prescription drug benefits, contact the Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD: 1-800-855-2881).

About Your Plan

Prescription medications are covered by the plan only if they have been approved by the U.S. Food and Drug Administration (FDA). In addition, with the exception of the over-the-counter version of Prilosec® (Prilosec OTC®), medications are covered only if a prescription is required for their dispensing. Diabetic supplies are also covered by the plan.

The plan categorizes medications into four major categories:

Generic Drugs
Generic prescription drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The FDA approves both brand name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand name drugs. These requirements assure that generic drugs are as safe and effective as brand name drugs.

Preferred Brand Name Drugs
A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Non-Preferred Brand Name Drugs
A non-preferred brand name drug, or non-formulary drug, is a medication that usually has a therapeutic alternative generic or preferred brand name drug.

Over-the-Counter (OTC) Drugs
Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC® (which is covered if dispensed with a written prescription).

One of the ways your plan maintains coverage of quality cost-effective medications is a multi-tier copayment pharmacy benefit. Copayments will change July 1, 2005 for several medications. The following chart shows your copayment based on the type of prescription you fill and where you get it filled.

Copayment for	Participating Retail Pharmacy up to a 30-day supply	Home Delivery (Mail Order) up to a 90-day supply
Tier 1 **Generic Drugs** All generic drugs *except:* • omeprazole *(acid reducer)* • Value Tier generics • Also covered: Prilosec OTC® *(28-day supply – retail; 84-day supply – mail)**	$7	$14
Tier 2 **Preferred Brand Name Drugs** All preferred brand name drugs *except:* • COX-2 inhibitors *(pain and inflammation – Celebrex®)* • Brand proton pump inhibitors *(acid reducers – currently Aciphex®, Nexium®, Prilosec®, Prevacid®, Protonix®)*	$20	$40
Tier 3 **Non-Preferred Brand Name Drugs** All non-preferred brand name drugs *plus:* • COX-2 inhibitors • Brand proton pump inhibitors • omeprazole	$40	$70
Value Tier • Generic Statin *(cholesterol lowering – lovastatin)* • Generic h-2 antagonists *(acid blockers – cimetidine 300, 400 and 800mg; famotidine 40mg; nizatidine 150 and 300mg; ranitidine 300mg)*	$2	$4

**** due to manufacturer packaging***

How to Use the Plan

Filling Your Prescriptions

You have two ways to fill your prescriptions: at a participating retail pharmacy or through Express Scripts Home Delivery (Mail Order).

To obtain benefits at a retail pharmacy, you must fill your prescription at a participating pharmacy using your Express Scripts ID card, with the exception of the limited circumstances detailed in the Claim Forms section on page 15.

Short-Term Medication Needs – Up to 30 Days

Filling Your Prescriptions at a Participating Retail Pharmacy

The retail pharmacy is your most convenient option when you are filling a prescription for a short-term prescription that you need immediately (example: antibiotics for strep throat or painkillers for an injury). Simply present your Express Scripts ID card to your pharmacist, with your written prescription, and pay the required copayment. Prescriptions filled at a non-participating retail pharmacy are not covered.

You can locate the nearest participating retail pharmacy anytime online at www.express-scripts.com or by calling 1-877-828-9744.

If you do not have your ID Card, you can provide your pharmacist with the cardholder's Social Security or GIC ID number, and the group number, which is GICA. The pharmacist will also be able to verify eligibility by contacting the Express Scripts Pharmacy Help Desk toll free at 1-800-824-0898 (TDD: 800-842-5754).

Long-Term Medication Needs

Filling Your Prescriptions Through Express Scripts Pharmacy

Home Delivery (Mail Order) is your best option for prescription drugs you take on a regular basis for conditions such as asthma, heartburn, high blood pressure, allergies and high cholesterol. Your prescriptions are filled and double-checked by Express Scripts' licensed pharmacists and conveniently sent to you in a plain, weather-resistant pouch for privacy and protection.

Convenient for You

You get up to a 90-day supply of your medications – which means fewer refills and fewer visits to your pharmacy, as well as lower copayments. Once you begin using Home Delivery, you can order refills online, by phone or by mail.

Using Home Delivery
To begin using Home Delivery for your prescriptions, just follow these three simple steps:

1. Ask your physician to write a prescription for up to a 90-day supply of your medication plus refills for up to one year, if appropriate. (Remember also to ask for a second prescription for an initial 30-day supply and take it to your local participating retail pharmacy.)
2. Complete a Home Delivery order form. (You can obtain a Home Delivery order form and envelope anytime online at www.express-scripts.com or by calling 1-877-828-9744.)
3. Insert your prescription, payment and completed order form into the mail order envelope and mail it to Express Scripts.

Your prescription drug will be mailed to your home in 10 to 14 business days from the day you mailed the prescription to Express Scripts, with no charge for standard U.S. Postal Service delivery. You can request overnight delivery for an additional charge.

A pharmacist is available 24 hours a day to answer your questions about your medication.

If the Express Scripts pharmacy is unable to fill a prescription because of a shortage of the medication, Express Scripts will notify you of the delay in filling the prescription. You may then attempt to fill the prescription at a retail pharmacy, but the retail pharmacy copayment will then apply.

Claim Forms

Retail purchases out of the country, or purchases at a participating retail pharmacy without the use of your Express Scripts ID Card, are covered as follows:

Type of Claim	Reimbursement
Claims for prescriptions for enrollees who reside in a nursing home or live or travel outside the U.S. or Puerto Rico.*	Claims will be reimbursed at the full cost submitted less the applicable copayment.
Claims for purchases at a participating (in-network) pharmacy without an Express Scripts ID card.	Claims incurred within 30 days of the enrollee's eligibility effective date will be covered at full cost, less the applicable copayment. -or- Claims incurred more than 30 days after the enrollee's eligibility effective date will be reimbursed at a discounted cost, less the applicable copayment.

* Claims for medications filled outside the United States and Puerto Rico are covered only if the medications have U.S. equivalents.

Visit express-scripts.com

Get the Information You Need When You Need It

Express-scripts.com provides 24-hour online access to information regarding your prescription benefit. Visit the Web site today to:

- Find out about your copayment amounts
- Verify coverage for eligible dependents
- View or print a list of drugs included in your formulary
- Locate participating retail pharmacies near you
- Review your 12-month prescription history
- Order refills online
- Check the status of your mail order prescription

Register Now to Access express-scripts.com

Accessing your prescription benefit online is quick, easy and secure; just go to www.express-scripts.com and complete a brief registration process to get started. You'll have the information you need about your prescription benefits, right at your fingertips.

Other Plan Provisions

Generics Preferred

Generics Preferred is a program that encourages the use of generic drugs. There are some brand name drugs, such as Prozac and Prinivil, for which generic equivalents are available. If you fill a prescription for a brand-name medication for which there is a generic equivalent, the standard generic copayment will not apply. Instead, you will be responsible for the full difference in price between the brand-name drug and the generic drug, plus the generic copayment.

Prior Authorization

Some drugs on your plan need prior authorization. If a drug you take requires prior authorization, your physician will need to contact Express Scripts to see if the prescription meets the plan's conditions for coverage. If you are prescribed a drug that requires prior authorization, your physician should call 1-800-417-8164.

Drugs that currently require Prior Authorization:

- Aranesp®, Epogen®, Procrit®
- Weight Loss Medications
- Growth Hormones
- For members over the age of 35: Retin A®, Differin®, Axita®
- Prolastin®
- Botox®
- Lamisil®, Sporanox®
- Tazorac®, Regranex®
- Penlac®
- Amevive®
- Forteo®
- Actiq®
- Enbrel®
- Humira®
- Raptiva™
- Sodium chloride injectable
- Topamax®
- Vfend®
- Xolair®
- Zonegram®

This list may change during the plan year.

Quantity Per Dispensing Limits/Allowances

To promote member safety and appropriate and cost-effective use of medications, your prescription plan includes a drug quantity management program. This means that for certain prescription drugs, there are limits on the quantity of the drug that you may receive at one time.

Quantity per dispensing limits/allowances are based on the following:

- The manufacturer's recommended dosage and duration of therapy
- Common usage for episodic or intermittent treatment
- FDA-approved recommendations and/or clinical studies
- As otherwise determined by your plan

Drugs with quantity limits currently include Cialis®, Imitrex®, Lamisil®, Levitra®, Maxalt®, Prevacid®, Prilosec®, Relenza®, Sporanox®, Tamiflu®, Viagra® and Zomig®. This list may change during the plan year.

Step Therapy

In some cases, your plan requires the use of less expensive first-line prescription drugs before the plan will pay for more expensive second-line prescription drugs. First-line prescription drugs are safe and effective medications used for the treatment of medical conditions or diseases. Your prior claims history, if you are a continuing member of the plan, will show whether first-line prescription drugs have been purchased within the previous 130 days, allowing the more-expensive medication to be approved without delay. If you have not had a medication filled within the previous 130 days while a member of this plan, it is not considered a current prescription and the Step Therapy requirements will apply to your prescription.

If you have previously used a first-line prescription drug and the drug has proven to be ineffective, a more expensive second-line prescription drug may be used. For instance, with stomach acid Step Therapy, ranitidine or cimetidine are examples of first-line prescriptions that could be tried prior to second-line agents such as Prevacid® or Nexium®.

In certain situations a member may be granted an authorization for a second-line prescription drug if specific medical criteria have been met without the trial of a first-line prescription drug.

Current examples of second-line prescription drugs requiring Step Therapy:

Stomach Acid:	Prilosec®, Prevacid®, Protonix®, Nexium®, and Aciphex®
Pain/Arthritis:	Celebrex®, Arthrotec®, Mobic®, Ponstel®, Enbrel®, Kineret®, and Humira®
Allergies:	Singulair®, Accolate®, and Zyflo®
High Blood Pressure:	Altace®, Accupril®, Aceon®, Monopril/HCT®, Uniretic®, Lexxel®, Lotrel®, Tarka®, Mavik®, Cozaar/HCT®, Micardis/HCT®, Tevetan®, Atacand/HCT®, Avapro®, Avalide®, and Diovan/HCT®
Topical Dermatitis:	Elidel® and Protopic®
ADD/ADHD:	Strattera®
Antidepressants:	Paxil CR®, Zoloft®, Celexa®, and Lexapro®, Effexor®, Effexor XR®, Cymbalta® and Wellbutrin XL®
Antipsychotic:	Symbyax™
Antianxiety:	Xanax XR®, Tranxene SD®, and Paxipam®

This list may change during the plan year.

Unless you meet certain medical criteria or have a prior history of use of the first-line prescription drug, your pharmacist will receive a message that the prescription will not be covered. The message will specify what kind of alternative drugs could be used. You or your pharmacist will then need to contact your physician to have your prescription changed, or you will have to pay the full cost of the prescription. If you are using Home Delivery, Express Scripts will notify you of a delay in filling your prescription and will contact your physician about switching to a first-line prescription drug. If your physician does not respond within two business days, Express Scripts will not fill your prescription and will return it to you.

Drug Utilization Review Program

Each prescription drug purchased through this program is subject to utilization review. This process evaluates the prescribed drug to determine if any of the following conditions exist:

- Adverse drug-to-drug interaction with another drug purchased through the program;
- Duplicate prescriptions;
- Inappropriate dosage and quantity; or
- Too early refill of a prescription.

If any of the above conditions exist, medical necessity must be determined before the prescription drug can be processed.

Exclusions

Benefits exclude:

- Smoking cessation programs or medications
- Dental preparations
- Over-the-counter drugs, vitamins or minerals (with the exception of diabetic supplies and Prilosec OTC®)
- Vitamins or minerals prescribed in the absence of certain medical conditions (with the exception of prenatal vitamins)
- Homeopathic drugs
- Prescriptions for cosmetic purposes
- Medications in unit dose packaging
- Prescription drugs with over-the-counter (OTC) equivalents with the same strengths, routes of administration, active chemical ingredients and dosage forms as the prescription drug products
- Special medical formulas or food products, except as required by state law.

Specialty Medications

Specialty medications are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/AIDS, Rheumatoid Arthritis, Cancer, Hepatitis B & C, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty medications may be obtained directly from the CuraScript Pharmacy, an ESI network pharmacy.

CuraScript is a leading provider of specialty medications and provides comprehensive and convenient specialty pharmacy services – at no additional cost to you.

Why should you use CuraScript for your specialty prescriptions?

CuraScript specializes in oral and injectable specialty medications. CuraScript:

- Assigns you a Patient Care Coordinator who serves as your personal advocate and your point of contact. This highly trained individual works closely with your physician to obtain prior authorizations, if necessary, and will even contact you when it's time to refill your prescription.
- Has a complete specialty pharmacy inventory with many specialty medications that are not readily available at a local pharmacy.
- Delivers your specialty medications directly to you or your physician.
- Provides you with the necessary supplies you need to administer your medications – at no additional cost.
- Offers clinically based care management programs – which include consultation with your physician – to help you get the most benefit from the specialty medications that your physician has prescribed for you.

How to Get Started with CuraScript

To begin utilizing the CuraScript Pharmacy (or to obtain a list of specialty medications covered through your Prescription Drug Program), you or your physician may call the CuraScript customer service line at 1-866-848-9870.

Definitions

Brand Name Drug – The brand name is the trade name under which the product is advertised and sold, and is protected by patents so that it can only be produced by one manufacturer for 17 years. Once a patent expires, other companies may manufacture a generic equivalent, providing they follow stringent FDA regulations for safety.

Copayment – A copayment is the amount that members pay for covered prescriptions. If the plan's contracted cost for a medication is less than the applicable copayment, the member pays only the lesser amount.

Diabetic Supplies – Diabetic supplies include needles, syringes, test strips, lancets and blood glucose monitors.

Formulary – A formulary is a list of recommended prescription medications that is created, reviewed and continually updated by a team of physicians and pharmacists. The Express Scripts formulary contains a wide range of generic and brand name preferred products that have been approved by the Food and Drug Administration (FDA). The formulary applies to medications that are dispensed in either the retail pharmacy or mail service settings. The formulary is developed and maintained by Express Scripts. Formulary designations may change as new clinical information becomes available.

Generic Drugs – Generic prescription drugs have the same active ingredients in the same dosage form and strength as their brand-name counterparts. The U.S. Food and Drug Administration (FDA) approves both brand-name and generic drugs and requires generics to have the same active ingredients and be absorbed in the body the same way as brand-name drugs. These requirements assure that generic drugs are as safe and effective as brand-name drugs.

Non-Preferred Brand Name Drug – A non-preferred brand name drug, or non-formulary drug, is a medication that has been reviewed by the Express Scripts Pharmacy and Therapeutics Committee, which determined that an alternative drug that is clinically equivalent and more cost effective may be available.

Over-the-Counter (OTC) Drugs – Over-the-counter drugs are medications that do not require a prescription. Your plan does not provide benefits for OTC drugs, with the exception of Prilosec OTC® (which is covered if dispensed with a written prescription).

Participating Pharmacy – A participating pharmacy is a pharmacy in the Express Scripts nationwide network. All major pharmacy chains and most independently owned pharmacies participate.

Preferred Brand Name Drugs – A preferred brand name drug, also known as a formulary drug, is a medication that has been reviewed and approved by a group of physicians and pharmacists, the Express Scripts Pharmacy and Therapeutics Committee, and has been selected by Express Scripts for formulary inclusion based on its proven clinical and cost effectiveness.

Prescription Drug – A prescription drug is any medical substance, the label of which under the Federal Food, Drug, and Cosmetic Act, must bear the legend: "Caution Federal Law prohibits dispensing without a prescription." The term prescription drug includes allergy extracts and insulin.

Prior Authorization – Prior Authorization means determination of medical necessity. It is required before prescriptions for certain drugs will be paid by the plan.

Special Medical Formulas or Food Products – Special medical formulas or food products means nonprescription enteral formulas for home use for which a physician has issued a written order and which are medically necessary for the treatment of malabsorption caused by Crohn's disease, ulcerative colitis, gastroesophageal reflux, gastrointestinal motility, chronic intestinal pseudo-obstruction, and inherited diseases of amino acids and organic acids. For inherited diseases of amino acids and organic acids, food products modified to be low protein are covered up to $2,500 per calendar year per member. To access the benefit for special medical formulas or food products, members must first call the Group Insurance Commission at 1-617-727-2310, extension 1.

Other Plan Information

Claims Inquiry

If you believe your claim was incorrectly denied or you have questions about a prescription, call Express Scripts Customer Service Call Center toll free at 1-877-828-9744 (TDD number 1-800-855-2881).

Appeal Rights for Prior Authorization Denials

Denials of request for Prior Authorization may be appealed by having your physician send a letter explaining why the product is medically necessary for you. This letter should be sent to Express Scripts, Prior Authorization, PO Box 39842, Bloomington, MN 55439-0842. Submission of appeal is not a guarantee of coverage.

Health and Prescription Information

Health and prescription information about members is used by Express Scripts to administer your benefits. As part of the administration, Express Scripts may report health and prescription information to the administrator or sponsor of your benefit plan. Express Scripts also uses that information and prescription data gathered from claims nationwide for reporting and analysis without identifying individual members.

Commonwealth
Indemnity Plan
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PO Box 9016
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Important Information Enclosed
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